## **Bedford Board of Health**

## 2016 - 2017 Insurance Information Form for Vaccination

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): \*Required Fields

1	Name: (Last, First, MI)*					Date of birth: *		Age*	Age* Sex: (Circle)*				
					Mc	nth Day	Year		Male	Female			
Street Add	lress:*				<b>L</b>			L					
City:*				State	*	Zip:*	Ph	one:*					
surance I	nformation:	Include the	whole men	nber ID i	number	and any le	tters that	are part o	that number	er			
Name of Ir	Name of Insurance Company:*  Memb				ber ID Number:*				Group ID Number: (if available)				
Medicare N	Medicare Number: Is Me					edicare Primary? Yes No				Is Subscriber Employed? Yes No			
person get	tting vaccinate	ed is not the	subscriber	, please	complet	e the follow	ving:						
Subscriber's Name: (Last, First, MI)*						Subscriber's Date of Birth:			. (				
						Month Day Year			Male Female				
Subscriber	r's Street Addre	ess:* (If differ	ent from add	dress abo	ove)	•	·						
City:* State				State	*	Zip: * Phone:*							
Patient Re	elationship to Su	ıhscriher: (C	circle)*	Spouse	Cł	nild	Other	,					
		( )											
	<u>ne</u> , please ci	-							<u>ounger:</u> ple	ase chec	k the b		
•	erson to be va		•			-		at are ap					
<ol><li>Does the person to be vaccinated have an allergy to a component of the vaccine? Y N</li></ol>					Is Vaccine for Children (VFC) Program eligible:   Is enrolled in Medicaid (includes MassHealth and HMOs etc. if								
	nponent of the	3. Has the person to be vaccinated ever had					enrolled through Medicaid)  Does not have health insurance						
to a con	•		ever had			Does not h			: A1	oalzo Notiva			
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